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103D CONGRESS
1ST SESSION

H. R. 3652

To improve the competitiveness, efficiency, and fairness of health coverage for individuals and small employers through promoting the development of voluntary Health Plan Purchasing Cooperatives.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 22, 1993

Mrs. JOHNSON of Connecticut (for herself, Mr. THOMAS of California, Mr. MCMILLAN, and Mr. GUNDERSON) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce and Ways and Means

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A BILL

To improve the competitiveness, efficiency, and fairness of health coverage for individuals and small employers through promoting the development of voluntary Health Plan Purchasing Cooperatives.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Plan Purchasing Cooperative Act of 1993''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. ESTABLISHMENT OF STANDARDS; APPLICATION IN STATES.

(a) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish standards under this Act to carry out the requirements of this Act, including standards relating to—

(A) the establishment of Health Plan Purchasing Cooperatives,

(B) qualifications for Accountable Health Plans,

(C) the roles of States under this Act, and

(D) standard benefit package for small employers.

(2) DEADLINE.—The Secretary shall establish and publish such standards by not later than 6 months after the date of the enactment of this Act.

(3) REVISION.—The Secretary from time to time may revise standards established under this

subsection. Such revisions shall only become effective in a manner that permits States sufficient time to change laws and regulations in order to implement such revisions.

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF STANDARDS.—

(A) IN GENERAL.—Subject to subsection (c), each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on steps the State is taking to establish and operate Health Plan Purchasing Cooperatives in accordance with the standards established under subsection (a) in all parts of the State, and to conform its insurance laws to meet the requirements of this Act, not later than such deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date the standards are established under subsection (a).

(ii) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary

identifies, in consultation with the National Association of Insurance Commissioners, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for insurers and health plans offered to meet the standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by

the deadline specified under paragraph (1) or finds that the State has not established and have in operation Health Plan Purchasing Cooperatives in accordance with the standards established under subsection (a), the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to comply with such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the establishment and operation of Health Plan Purchasing Cooperatives in accordance with such standards in the State as the Secretary determines to be appropriate. Such implementation shall take effect with respect to insurers, and health plans offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected.

(c) WAIVER OF APPLICATION IN A STATE.—Subsection (b) shall not apply in a State if the State demonstrates to the satisfaction of the Secretary that the State has established an alternative method for assuring access of every eligible individual and eligible employee to health coverage.

(d) IMPLEMENTATION.—The report under subsection (b) shall specify the State official (or officials), or State board, commission, or department, responsible for carrying out the standards under subsection (a).

SEC. 3. SPECIFICATION OF HEALTH PLAN PURCHASING COOPERATIVE AREAS.

(a) IN GENERAL.—Each State shall establish boundaries for health plan purchasing cooperative areas in the State.

(b) STANDARDS.—Each part of the State shall be in one, and only one, health plan purchasing cooperative area. Each such area shall include a sufficient number of potential enrollees, health care providers, and Accountable Health Plans to carry out the purposes of this Act.

(c) REVISIONS.—A State may revise the boundaries of health plan purchasing cooperative areas not more frequently than annually.

SEC. 4. ESTABLISHMENT OF HEALTH PLAN PURCHASING COOPERATIVES.

(a) IN GENERAL.—Each State shall establish in accordance with this section one or more State-chartered, nonprofit private organizations to serve as the Health Plan Purchasing Cooperatives for each health plan purchasing cooperative area specified under section 3 for the

benefit of small employers and eligible individuals in the area.

(b) BYLAWS AND BOARD OF DIRECTORS.—

(1) BYLAWS.—Each Health Plan Purchasing Cooperative shall establish bylaws, consistent with this section, for its operation, including the election of members of its board of directors.

(2) BOARD OF DIRECTORS.—

(A) IN GENERAL.—Each Health Plan Purchasing Cooperative shall operate under the supervision of a board of directors. A majority of the members of the board shall be small employers or eligible individuals that participate in the Cooperative.

(B) APPOINTMENT AND ELECTION.—The State shall provide for the appointment of initial members to the board of directors of each Health Plan Purchasing Cooperative. Subsequent members of the board of directors of a Health Plan Purchasing Cooperative shall be elected by small employer members and individual members of the Cooperative in accordance with bylaws of the Cooperative. Such elections shall occur not less frequently than once every 2 years.

(3) LIMITATION ON LIABILITY.—There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member of the board of directors of a Health Plan Purchasing Cooperative, or its employees or agent, for any action taken in good faith by them in the performance of duties of plan purchasing cooperatives specified in this Act.

(c) OFFICERS AND EMPLOYEES.—Each Health Plan Purchasing Cooperative shall provide, consistent with its bylaws, for—

(1) the appointment of officers from among its members, and

(2) the appointment of an executive director to serve as the chief operating officer of the Cooperative.

(d) ADVISORY COMMITTEES.—Each Health Plan Purchasing Cooperative shall establish such advisory committees as may be necessary to assist in carrying out its duties under this Act. Such an advisory committee may include representation from Accountable Health Plans, agents, and health care providers.

(e) ANNUAL REPORT; RECORDS; AUDIT.—Each Health Plan Purchasing Cooperative shall—

(1) prepare, and submit to the State and the Secretary, an annual report on its operations, including its program and financial operations;

(2) conduct such annual internal and independent audits as it determines to be appropriate; and

(3) maintain records on its operations.

(f) GENERAL AUTHORITIES; LIMITATIONS ON AUTHORITY.—

(1) IN GENERAL.—A Health Plan Purchasing Cooperative may—

(A) sue (or be sued), and

(B) subject to paragraph (2), accept and expend grants or funds from any public or private agency.

(2) LIMITATIONS.—A Health Plan Purchasing Cooperative may not—

(A) purchase health care services;

(B) assume risk for the cost or provision of health care services;

(C) contract directly with health care providers (other than with Accountable Health Plans under section 5) for the provision of health care services for members; or

(D) accept any funds from any private agency that is (or is affiliated with) an Ac-

countable Health Plan or other party that would pose a conflict of interest (as specified by the Secretary).

SEC. 5. FUNCTIONS OF HEALTH PLAN PURCHASING CO-OPERATIVES.

(a) CONTRACTS WITH ACCOUNTABLE HEALTH PLANS; ENROLLMENT IN PLANS.—

(1) CONTRACTS WITH PLANS.—Each Health Plan Purchasing Cooperative shall enter into contracts and hold policies with Accountable Health Plans which elect to offer qualified health benefit benefits to members, in accordance with subsection (d).

(2) ENROLLMENT.—

(A) IN GENERAL.—Each Health Plan Purchasing Cooperative shall provide for the enrollment of eligible employees of small employers and eligible individuals in qualified health benefit plans of Accountable Health Plans offered by the Cooperative.

(B) OPEN ENROLLMENT PERIODS.—Each Health Plan Purchasing Cooperative shall provide for an annual open enrollment period of 30 days to be available within 60 days before the

anniversary date of each member's coverage under a qualified health benefit plan.

(3) PROVISION OF INFORMATION.—Each Health Plan Purchasing Cooperative shall provide to its members and eligible employees of small employer members comparison sheets, in accordance with standards established by the Secretary, which provide clear standardized information on each Accountable Health Plan and each qualified health benefit plan offered by an Accountable Health Plan, including information on price, consumer satisfaction, and (if feasible) health outcomes and enrollment and enrollee responsibilities and obligations.

(b) MEMBERSHIP REQUIREMENTS.—

(1) IN GENERAL.—Each Health Plan Purchasing Cooperative shall establish requirements for participation of small employers and eligible individuals as members of the Cooperative consistent with any standards the Secretary establishes consistent with this subsection. Each Cooperative shall maintain eligibility records to carry out its functions.

(2) SMALL EMPLOYER STANDARDS.—Under such standards—

(A) each small employer in the area that meets requirements for membership is permitted to become a member;

(B) a small employer that is not a valid small employer group and was formed for the purpose of securing health benefits coverage shall be denied membership;

(C) each small employer member shall offer to eligible employees a choice of at least 3 different health insurance plans, of which—

(i) at least one provides medisave coverage consistent with section 12,

(ii) at least one is a fee-for-service plan, and

(iii) at least one is a managed care plan;

(D) no small employer is required, as a condition of membership, to make any contribution towards the premium for coverage of any eligible employee; and

(E) if a small employer member terminates coverage purchased through the Health Plan Purchasing Cooperative, the former member shall be ineligible to purchase a health insur-

ance plan through the Cooperative for a period of 12 months.

(3) INDIVIDUAL MEMBERS.—Under such standards, eligible individuals residing in a health plan purchasing cooperative area may become individual members of the Health Plan Purchasing Cooperative for the area.

(4) PAYMENT OF PREMIUMS.—

(A) IN GENERAL.—A Health Plan Purchasing Cooperative may condition membership upon prepayment of a monthly premium (or compliance with other mechanisms) to assure that payment will be made for coverage of members on a timely basis.

(B) NOTIFICATION OF FAILURE TO RECEIVE PREMIUM.—If a Health Plan Purchasing Cooperative fails to receive payment on a premium due with respect to an individual covered under an Accountable Health Plan offered by the Cooperative, the Cooperative shall provide notice of such failure to the individual within the 20-day period after the date on which such premium payment was due.

(C) DIRECT PAYMENT ALLOWED IN CASE OF EMPLOYER NONPAYMENT.—In the case a

small employer member of a Cooperative fails to make payment of premiums due with respect to an eligible employee covered under an Accountable Health Plan offered through the Cooperative, the Cooperative shall notify such employee of such nonpayment and shall allow the employee to make direct payments to the Cooperative effective with the next succeeding payment period.

(5) DISPUTE RESOLUTION PROCEDURES.—Each Health Plan Purchasing Cooperative shall establish, in accordance with standards established under this Act dispute resolution procedures to resolve disputes between the Cooperative and its members and disputes between the Cooperative and Accountable Health Plans. Under such procedures, a member or Cooperative may appeal the proposed resolution of such a dispute to the State.

(c) CONTRACTS WITH MEMBERS.—

(1) PREMIUM PAYMENTS.—

(A) IN GENERAL.—Each contract between a member and a Health Plan Purchasing Cooperative shall provide that payment of all premiums shall be transmitted by the member (which in the case of a small employer member

shall be on behalf of eligible employees) to (or on behalf of) the Cooperative for the benefit of the Accountable Health Plan in which the eligible employee or individual is enrolled. The Cooperative shall provide for procedures for the collection of premiums from members (including, in the case of a small employer member, eligible employees).

(B) AT LEAST BIMONTHLY.—Such premiums are payable not less often than bimonthly.

(C) LATE CHARGES.—A Health Plan Purchasing Cooperative may provide for penalties for late payment.

(D) NONPAYMENT.—Nonpayment of premiums by a member shall constitute a breach of the contract, a breach of the health care policy, and a default on the member's obligation.

(2) CONTRACT HOLDER.—Such a contract shall provide that the Health Plan Purchasing Cooperative may be the contract holder of the health benefit policy on behalf of the member (including eligible employees). Any such contract shall provide that all eligible employees who obtain coverage under the health benefit plan offered by a small employer must

obtain such coverage through any qualified health benefit plan offered by an Accountable Health Plan through the Cooperative.

(3) PREMIUM AMOUNTS.—The amount of premiums imposed shall include an amount that includes the fixed overhead allowance percentage established by the Health Plan Purchasing Cooperative under subsection (e).

(d) CONTRACTS WITH PLANS.—

(1) IN GENERAL.—Each contract between an Accountable Health Plan and a Health Plan Purchasing Cooperative shall provide—

(A) that premiums of members shall be forwarded to the plan in which they are enrolled, subject to any adjustment under section 10, on the effective date of coverage (if that occurs more than once a month), on a monthly basis, or as agreed in the contract (but in no event less frequently than monthly); and

(B) that the Cooperative shall transmit enrollment and eligibility information to the plan on a timely basis.

(2) TERMINATION.—An Accountable Health Plan may not terminate such a contract unless the plan—

(A) provides advance notice to the Health Plan Purchasing Cooperative, and

(B) provides notice at least 180 days before the nonrenewal of any qualified health benefit plan to enrollees.

In the case of such a termination, the Accountable Health Plan shall not write new business with the Health Plan Purchasing Cooperative for a period of 3 years from the date of the notice of termination.

(e) OVERHEAD ALLOWANCE.—Each Health Plan Purchasing Cooperative shall establish a fixed overhead allowance percentage that shall be—

(1) applied as addition to the premiums charged for enrollment in an Accountable Health Plan offered through the Cooperative to its members, and

(2) used to cover administrative costs of the Cooperative, as well as defaults by members of premium payments.

(f) UNIFORM ADMINISTRATIVE AND ACCOUNTING PROCEDURES.—Each Health Plan Purchasing Cooperative shall establish with such uniform administrative and accounting procedures as needed to conform with applicable national standards identified by the Secretary.

(g) CONTRACTS FOR ADMINISTRATIVE SERVICES.—

(1) IN GENERAL.—Each Health Plan Purchasing Cooperative shall contract with a qualified, independent third party for any service necessary to carry out its duties under this Act. Such contracts shall include—

(A) contracts with agents to assist in contracting with Accountable Health Plans and small employer members, and

(B) contracts to market and publicize the availability of qualified health benefit plans through the Cooperative.

(2) INFORMATION.—Unless permission is specifically granted by the Cooperative, such a third party may not release, publish, or otherwise use any information to which the party has access under its contract.

(g) CONSTRUCTION.—Nothing in this Act shall be construed as requiring a small employer or eligible individual to obtain coverage from or through a Health Plan Purchasing Cooperative.

SEC. 6. ACCOUNTABLE HEALTH PLANS.

(a) DESIGNATION.—Each State shall establish a process whereby a carrier that demonstrates to the satisfaction of the State insurance commissioner that it has the capability to fulfill the following requirements (directly

or through subcontracts) is designated as an Accountable Health Plan for purposes of this Act:

(1) LICENSURE.—The carrier is licensed and in good standing with the State insurance commissioner (or other comparable official for a State).

(2) ADMINISTRATIVE CAPACITY.—The carrier has the capacity to administer qualified health benefit plans.

(3) ACCESS.—In the case of a carrier with a contractual obligation to provide or arrange for health services included in the qualified health benefit plan, the ability to provide enrollees with adequate access to these covered services within the carrier's service area.

(4) GRIEVANCE PROCEDURES.—The carrier has grievance procedures, including the ability to respond to enrollees' calls, questions, and complaints.

(5) UTILIZATION MANAGEMENT PROCEDURES.—The carrier has established utilization management procedures.

(6) QUALITY.—The carrier has the ability to monitor and evaluate the quality and cost-effectiveness of care.

(7) INFORMATION.—The carrier has the ability to provide information on enrollee satisfaction

(based on standard surveys described in section 9(b)(4)).

(8) DATA.—The carrier has the ability to provide standard data elements (identified under section 9(b)).

(b) FUNCTIONS OF ACCOUNTABLE HEALTH PLANS.—

(1) IN GENERAL.—In every Health Plan Purchasing Cooperative with which it has a contract under section 5(d), each Accountable Health Plan shall provide for activities described in this subsection.

(2) OFFERING PLAN.—Each such Accountable Health Plan shall offer qualified health benefit plans. If such a Plan offers a managed care plan in a State (or geographic area) to employers that are not small employers, the Plan shall offer a similar managed care plan to small employers in that State or geographic area.

(3) PERFORMANCE INFORMATION.—Each such Accountable Health Plan shall provide for the collection and reporting to the State and to the appropriate Health Plan Purchasing Cooperative of information on the performance of the plan regarding the

effectiveness in providing services, identified under section 9(b).

(4) USE OF ADJUSTED COMMUNITY RATING.—Each such Accountable Health Plan shall—

(A) establish premium rates for each qualified health benefit plan pursuant to a method that spreads financial risk across a large population and allows adjustments only for benefit design and the following demographic characteristics: age, gender, number of family members, and the health plan purchasing cooperative area in which coverage is provided; and

(B) file on a quarterly basis with the Health Plan Purchasing Cooperative in which it is participating the premium rates for qualified health benefit plans offered by the Plan.

(5) RATING, UNDERWRITING, ETC.—Each such Accountable Health Plan shall comply with all rules regarding rating, underwriting, claims handling, sales, solicitation, licensing, unfair trade practices, and other provision in this Act and under the applicable insurance laws of the State.

(6) GUARANTEED ISSUE AND REISSUE.—Each such Accountable Health Plan shall issue coverage under a qualified health benefit plan to any eligible

individual and any eligible employee (of a small employer member) who elects to be covered under a qualified health benefit plan offered by the plan in the manner required under this Act.

(7) RENEWAL.—Each such Accountable Health Plan shall renew each qualified health benefit plan with respect to any member (and any eligible employee of such a member) except in the case of—

(A) nonpayment of the required premium,

(B) fraud or material misrepresentation of the member (or employee) or the member's or employee's dependents, and

(C) repeated misuse of a provider network provision (including unreasonable refusal of the enrollee to follow a prescribed course of treatment, excessive use of emergency services for non-emergencies, or violation of contractual provisions), as specified by the State in which the plan is offered.

(8) NOTICE OF TERMINATION OF COOPERATIVE CONTRACT.—Each such Accountable Health Plan may only terminate its contract with the Cooperative in accordance with section 5(d)(2).

(9) GRIEVANCE PROCEDURES.—Each such Accountable Health Plan shall provide a procedure for

addressing grievances that arise between the plan and the Health Plan Purchasing Cooperative, members of the Health Plan Purchasing Cooperative (and, in the case of small employer members, their eligible employees) that requires both parties to fully exhaust the remedies provided under the procedure to resolve grievance before seeking any relief other than as provided in the procedure.

(10) USE OF UNIFORM CLAIMS FORMS.—Each Accountable Health Plan shall use standardized forms, including uniform claims forms, identified by the Secretary.

(c) COVERAGE.—

(1) IN GENERAL.—Coverage under a qualified health benefit plan offered by an Accountable Health Plan shall be available to any member at the anniversary date of each member's coverage under a qualified health benefit plan (or in the case of an employer or individual who has applied to become a member of a Health Plan Purchasing Cooperative when the member first joins the Cooperative).

(2) EXCEPTION.—An Accountable Health Plan is not required to offer coverage or accept enrollment if—

(A) the eligible individual or employee (or dependent) does not reside within the plan's service area (as approved by the State insurance commissioner);

(B) the plan provides 90 days prior notice that it will not have the capacity to deliver services adequately in the health plan purchasing cooperative area to additional enrollees because of its obligations to existing groups and enrollees; or

(C) the State insurance commissioner determines that the acceptance of an application or applications would place the plan in a financially impaired condition.

(3) CONDITIONS.—

(A) INSUFFICIENT CAPACITY.—An Accountable Health Plan that cannot offer coverage under paragraph (2)(B) may not offer coverage to the employees of a new employer group until the later of 90 days following such refusal or the date on which the plan notifies the Health Plan Purchasing Cooperative and the State insurance commissioner that it has regained capacity to deliver services to eligible

employees and their dependents in the service area.

(B) FINANCIAL IMPAIRMENT.—An Accountable Health Plan that cannot offer coverage under paragraph (2)(C) may not offer coverage or accept applications for any individual or employer group until a determination by the State insurance commissioner that acceptance of an application will not put the plan in a financially impaired condition.

(d) CONSTRUCTION.—Nothing in this Act (or in State law) shall—

(1) prohibit an Accountable Health Plan from providing a qualified health benefit plan in a Health Plan Purchasing Cooperative through a managed care system, and from contracting with particular health care providers or types, classes, or categories of health care providers;

(2) prohibit such a plan from establishing its own levels of payment and financial incentives for reimbursing health care providers providing health care services to enrollees; or

(3)(A) prohibit such a plan from performing utilization review of any or all treatments and conditions, (B) require the use of specified standards of

health care practice in such review, (C) impose residency or specialty restrictions on the entities conducting such a review, or (D) require the disclosure of the specific criteria used in such reviews.

State law is preempted to the extent it is inconsistent with the previous sentence.

(e) DEEMED COMPLIANCE.—Carriers which comply with any of the requirements of a paragraph of subsection (a) through a requirement of State law shall be deemed to be in compliance with the corresponding paragraph of such subsection. Carriers receiving accreditation by nationally recognized, health related accreditation organizations (including the National Committee on Quality Assurance, the Utilization Review Accreditation Commission, the Joint Commission on Accreditation of Health Care Organizations), or qualification by Federal agencies, shall be deemed in compliance with the requirements of subsection (a) as they pertain to the relevant accreditation activities of such organizations.

(f) DETERMINATIONS.—Each State shall provide for a determination of whether a carrier is an Accountable Health Plan within 30 days of a completed application being submitted to the State.

(g) TERMINATION.—After notice and hearing, a State may suspend or revoke the designation as an Ac-

countable Health Plan of a carrier that files to maintain compliance with the requirements in subsections (a), (b), and (c).

SEC. 7. QUALIFICATIONS FOR QUALIFIED HEALTH INSURANCE PLANS.

(a) IN GENERAL.—A health plan is not a qualified health benefit plan for purposes of this Act unless the plan—

(1) meets applicable financial requirements established under State law;

(2) is marketed only in accordance with section 8; and

(3) submits to the Health Plan Purchasing Cooperative data in accordance with standards established under section 9.

(b) MARKETING MATERIAL; AGENT COMPENSATION.—

(1) IN GENERAL.—An Accountable Health Plan may provide, directly or through an agent, broker, contractor, or producer, marketing materials approved by the State insurance commissioner. Such a plan does not require authorization by a Health Plan Purchasing Cooperative for advertisement to the public at large through the means of mass media.

(2) AGENT COMPENSATION.—An Accountable Health Plan may not vary compensation or commissions to such an agent, broker, contractor, or producer based, directly or indirectly, on the anticipated or actual claims experience or health status associated with particular small employers or eligible individuals to which each plan is sold.

(3) LIMITATIONS ON BROKER ACTIVITIES.—No Accountable Health Plan (or agent, broker, contractor, or producer for such a plan) shall engage, directly, or indirectly, in any activity or marketing practice that would encourage small employers or eligible individuals to refrain from enrolling in the plan, or seek coverage from another Accountable Health Plan, because of the health status or claims experience of the employer or individual.

SEC. 8. MARKETING QUALIFIED HEALTH BENEFIT PLANS.

(a) IN GENERAL.—Each Health Plan Purchasing Cooperative shall use efficient and standardized means to notify small employers of the availability of health coverage through the Cooperative.

(b) MARKETING MATERIALS.—Each Health Plan Purchasing Cooperative shall make available to small employer and individual members marketing materials that accurately summarizes the benefit plans, cost and other

relevant information concerning Accountable Health Plans offered by the Cooperative.

(c) USE OF BROKERS.—Nothing in this Act shall be construed to prohibit a Health Plan Purchasing Cooperative or Accountable Health Plan from using the services of an agent, broker, contractor, or producer in order to assist in marketing.

(d) MONITORING.—Each Health Plan Purchasing Cooperative shall notify the State insurance commissioner (or other official identified by the State) of any marking practices or materials that it finds contrary to the fair and affirmative marketing of Accountable Health Plans under this Act.

(e) STATE ROLE.—Each State insurance commissioner shall monitor compliance with the marketing requirements of this Act, including the conduct of agents, brokers, contractors, and producers and investigate complaints of violations of such requirements.

SEC. 9. COLLECTION AND SUBMISSION OF DATA.

(a) FROM HEALTH PLAN PURCHASING COOPERATIVES TO STATES.—Each Health Plan Purchasing Cooperative shall submit such data to the State, on a quarterly basis, as the Secretary may specify. Such data shall include the following:

(1) With respect to small employer members—

(A) employer enrollment by employer size, industry sector, previous insurance status, and number of eligible employees within each small employer, and

(B) number of total eligible employers in the health plan purchasing cooperative area.

(2) With respect to eligible individuals, the demographic characteristics of such individuals, including age, gender, employment status and employment sector, and previous insurance status.

(3) Premium ranges for each qualified health benefit plan for Health Plan Purchasing Cooperative member categories.

(4) Cooperative overhead charges.

(5) Cooperative financial statements.

(b) COLLECTION OF DATA BY HEALTH PLAN PURCHASING COOPERATIVES.—

(1) IN GENERAL.—The Secretary shall establish uniform standards for data that a Health Plan Purchasing Cooperative collects from Accountable Health Plans and providers and disseminates.

(2) COLLECTION.—Under such standards, each Health Plan Purchasing Cooperative shall collect only such data as are necessary for evaluation of the performance of Accountable Health Plans and their

provider networks by consumers and providers. The Secretary shall establish such standards consistent with the method of operation of Accountable Health Plans, consistent with national health care data collection initiatives, consistent with not imposing an unreasonable cost of compliance on Accountable Health Plans, and only after a study of the feasibility and cost-effectiveness.

(3) DISSEMINATION.—Under such standards, each Health Plan Purchasing Cooperative shall release such data in a uniform and standardized format which compares all Accountable Health Plans or providers (as the case may be).

(4) ENROLLEE SATISFACTION SURVEYS.—All enrollee satisfaction surveys used by Accountable Health Plans in reporting to Health Plan Purchasing Cooperatives shall be in a standardized format promulgated by the Secretary.

SEC. 10. RISK ADJUSTMENT MECHANISM.

(a) MONITORING NEED.—Each State shall designate an entity to monitor adverse selection in enrollment among qualified health benefit plans offered through Health Plan Purchasing Cooperatives and the need for risk adjustment mechanisms to assure proper payment incentives to Accountable Health Plans.

(b) ESTABLISHMENT.—If there is a need, a State shall provide for the use of risk adjustment mechanisms (consistent with a model among the models identified under standards established under section 2) to adjust payment amounts among Accountable Health Plans to reflect the risk covered by each qualified health benefit plan offered by such a plan. A State shall also apply such a mechanism to health benefit plans sold to small employers and eligible individuals, other than through a Health Plan Purchasing Cooperative, if necessary.

SEC. 11. ROLE OF STATE; OVERSIGHT; EVALUATION.

(a) OVERSIGHT.—Each State shall—

(1) assure compliance of Health Plan Purchasing Cooperatives, small employers, and eligible employees and individuals with the requirements of this Act, and

(2) conduct reviews, not less frequently than annually, on the performance of each Health Plan Purchasing Cooperative in assuring access to health coverage to small employer and eligible individuals in the health plan purchasing cooperative area in accordance with this Act.

(b) DISPUTE RESOLUTION.—Each State shall receive, review, and act on appeals of disputes, between a

Health Plan Purchasing Cooperative and a member, not resolved by the Cooperative under section 5(b)(5).

(c) ASSURING AVAILABILITY OF COVERAGE TO ELIGIBLE INDIVIDUALS AND COMPARABLE TREATMENT IN AND OUT OF COOPERATIVES.—Each State shall provide by law that no qualified health benefit plan may be offered with respect to a small employer, or to individuals, in the State unless—

(1) it is offered to all small employers or eligible individuals (as the case may be) who are located or reside in the State in the service area of the plan;

(2) it meets standards relating to guaranteed renewability and limitations on the application of pre-existing condition limitations; and

(3) it—

(A) meets standards relating to rating practices, consistent with section 6(b)(4)(A), and

(B) is offered to all small employers or eligible individuals (as the case may be) at a premium rate that is the same (regardless of whether offered inside or outside a Health Plan Purchasing Cooperative), not taking into account any broker's fees or commissions.

(d) ANALYSIS OF INFORMATION.—Each State shall analyze information collected from Accountable Health Plans and other sources and report findings that assist consumers, Health Plan Purchasing Cooperatives, Accountable Health Plans, or health care providers in improving the delivery or purchase of cost-effective health care.

(e) DISSEMINATION OF INFORMATION.—Each State shall prepare and make available to Health Plan Purchasing Cooperatives and employers located in the State (and to eligible individuals upon request) information, in comparative form, concerning the qualified health benefit plans in such State and Health Plan Purchasing Cooperatives operating in the State. Such information shall include a description of the following:

(1) Such Cooperatives in the State and the qualified health benefit plans of Accountable Health Plans available with respect to each Cooperative.

(2) The existence of Health Plan Purchasing Cooperatives within each health plan purchasing cooperative area.

(3) Any other information determined appropriate by the State.

(f) ANNUAL REPORT.—Each State shall report to the Secretary, at such frequency (not more often than annu-

ally) as the Secretary may specify, on the impact of the reforms under this Act in expanding the availability and affordability of health coverage to eligible employees and eligible individuals.

(g) ANTITRUST PROTECTION.—Each State shall actively supervise Health Plan Purchasing Cooperatives to ensure that actions that affect market competition accomplish the objectives of this Act, so as to provide State and Federal protection to such Cooperatives and the board of directors of such Cooperatives against Federal and State laws intended to protect commerce from unlawful restraints, monopolies, and unfair business practices.

SEC. 12. DESCRIPTION OF MEDISAVE COVERAGE.

(a) IN GENERAL.—For purposes of this Act, a health insurance plan is considered to provide medisave coverage consistent with this section if such plan consists of—

(1) a qualified catastrophic health plan (as defined in subsection (b)(1)), and

(2)(A) there is a fixed dollar amount (in the form of a cash-value annuity) of additional benefits under such plan which does not exceed the plan's qualified catastrophic deductible (as defined in subsection (b)(2));

(B) the plan specifies the range of benefits to which the beneficiary may elect to have the amount applied, which—

(i) includes, at a minimum, payment of expenses countable towards the qualified catastrophic deductible and payment of premiums towards a long-term care insurance plan, and

(ii) does not include the purchase of any supplemental insurance for acute care benefits;

(C) any such amount of benefits not used shall be accumulated (with a rate of return specified in the plan), shall remain available to be applied against such range of benefits, shall be nonforfeitable, and, upon the death of all beneficiaries under the account, shall be payable in cash to the estate of the beneficiary who dies last; and

(D) the plan meets the portability rules established under subsection (c).

(b) QUALIFIED CATASTROPHIC HEALTH PLAN DEFINED.—In this section—

(1) QUALIFIED CATASTROPHIC HEALTH PLAN DEFINED.—The term ''qualified catastrophic health plan'' means any health plan provided to an employee which is certified by the Secretary of Health and Human Services as a plan—

(A) which provides no compensation for medical expenses not exceeding the qualified catastrophic deductible (as defined in paragraph (2)) in any year, and

(B) which provides full reimbursement for medical expenses exceeding the qualified catastrophic deductible during any year.

(2) QUALIFIED CATASTROPHIC DEDUCTIBLE DEFINED.—The term ''qualified catastrophic deductible'' means—

(A) $2,000, or

(B) $4,000 if the qualified catastrophic health plan provides coverage for more than one individual.

In the case of any calendar year after 1994, the dollar amounts in subparagraphs (A) and (B) shall be increased by an amount equal to such dollar amount, multiplied by the cost-of-living adjustment determined under section 1(f)(3) of the Internal Revenue Code of 1986 for such calendar year. If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

(3) QUALIFIED MEDICAL EXPENSES DEFINED.—

(A) IN GENERAL.—The term ''qualified medical expenses'' means medical expenses of an employee other than amounts paid for insurance or for a health plan.

(B) MEDICAL EXPENSES DEFINED.—The term ''medical expenses'' means amounts paid by the employee for medical care (as defined in section 213 of the Internal Revenue Code of 1986) of such individual, the spouse of such individual, and any dependent (as defined in section 152 of such Code) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

(c) PORTABILITY RULES.—In the case of an individual who has medisave coverage described in subsection (a)(2) under a health insurance plan in a year, who terminates enrollment under the plan or terminates catastrophic coverage under the plan, and who has accumulated an amount of benefits under such coverage, the plan shall permit the individual (as elected by the individual) and in accordance with standards established under section 2—

(1) to have the plan pay an amount equal to all or some of the amount of benefits accumulated

under such coverage towards the payment of premiums under—

(A) any health insurance plan,

(B) any employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, (other than such a plan described in section 13(10)(B)), or

(C) a long-term care insurance plan,

providing coverage for the individual; and

(2) to have the plan transfer an amount equal to all or some of the remaining balance to another health insurance plan that will provide medisave coverage for that individual in accordance with the requirements of this subsection (and such other plan shall credit such amount transferred towards medisave coverage under that plan).

SEC. 13. TAX TREATMENT OF MEDISAVE COVERAGE.

(a) GENERAL RULE.—For purposes of the Internal Revenue Code of 1986—

(1) any health insurance plan which provides Medisave coverage consistent with section 12 of this

Act shall be treated as an accident and health insurance contract,

(2) amounts (other than policyholder dividends, premium refunds, or amounts payable under section 12(a)(2)(C) of this Act) received under such coverage shall be treated as amounts received for personal injuries and sicknesses and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d) of such Code),

(3) any plan of an employer providing Medisave coverage consistent with section 12 of this Act shall be treated as an accident and health plan, and

(4) amounts paid for Medisave coverage consistent with section 12 of this Act shall be treated as medical expenses for purposes of section 213 of such Code.

(b) USE OF FLEXIBLE SPENDING ACCOUNTS.—The Secretary of the Treasury or his delegate shall revise the regulations prescribed under section 125 of the Internal Revenue Code of 1986 so as to permit the use of health-related flexible spending accounts under such section in a manner similar to that provided in subsection (a)(2) of section 12 of this Act.

SEC. 14. DEFINITIONS.

In this Act:

(1) ACCOUNTABLE HEALTH PLAN.—The term ''Accountable Health Plan'' means a carrier is designated under section 6(a) by a State insurance commissioner.

(2) CARRIER.—The term ''carrier'' means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering such a plan, and includes a similar organization regulated under State law for solvency.

(3) DEPENDENT.—The term ''dependent'' means, with respect to a person—

(A) the spouse of the person, and

(B) a child (including an adopted child) of the person who—

(i) is under 19 years of age,

(ii) is under 25 years of age and a full-time student, or

(iii) regardless of age is incapable of self-support because of mental or physical disability.

(4) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, an employee who normally performs on a monthly basis

at least 30 hours of service per week for that employer.

(5) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means an individual residing in the United States who is a citizen or national of the United States or an alien lawfully residing permanently in the United States, if the individual is not an eligible employee or otherwise eligible for health insurance coverage under an employment-based health insurance or under a Federal or State health program.

(6) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(7) HEALTH PLAN PURCHASING COOPERATIVE.—The term ''Health Plan Purchasing Cooperative'' means a State-chartered, nonprofit organization that provides health coverage purchasing services to members in a health plan purchasing cooperative area regarding qualified health benefit plans offered by Accountable Health Plans and that is established under section 4.

(8) HEALTH PLAN PURCHASING COOPERATIVE AREA.—The term ''health plan purchasing coopera-

tive area'' means an area designated under section 3.

(9) HEALTH PLAN PURCHASING COOPERATIVE BOARD.—The term ''Health Plan Purchasing Cooperative board'' means the board of directors of a Health Plan Purchasing Cooperative.

(10) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance plan'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group or individual contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

(i) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical-payment insurance,

or any combination thereof.

(11) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes, as determined under standards established by the Secretary, a health insurance plan that meets specified standards and that offers to provide health services on a prepaid, at-risk basis primarily through a defined set of providers.

(12) MEMBER.—The term ''member'' means, with respect to a Health Care Purchasing Cooperative, a small employer or eligible individual that meets membership requirements for the Cooperative under section 5(b).

(13) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(14) SERVICE AREA.—The term ''service area'' means a geographic region in which a carrier is licensed to operate.

(15) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 101 eligible employees on a typical business day in any 3-consecutive-month-period in the

year. For the purposes of this paragraph, the term ''employee'' includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

(16) SMALL EMPLOYER MEMBER.—The term ''small employer member'' means, with respect to a Health Plan Purchasing Cooperative, a small employer that is a member of the Cooperative.

(17) STATE.—The term ''State'' means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(18) STATE INSURANCE COMMISSIONER.—The term ''State insurance commissioner'' includes a State superintendent of insurance and includes, with respect to a health maintenance organization or other carrier not regulated by such an official, such State official as is responsible for regulation of the organization or carrier.

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